OPERATIONAL WEBINAR SERIES:

HOW TO BILL MEDICARE CROSSOVERS IN PROVIDERONE

- Copy of this presentation located at http://hrsa.HCA.wa.gov/providerone/Webinars/MedicareCrossovers.ppt

Washington State
Health Care Authority

Learning Objectives

- After this webinar, you will be able to:
  - Verify if a Client has Medicare and determine the type of coverage they have
  - Bill Medicare crossovers on professional and institutional claim formats electronically
  - Better understand the Payment Methodology for Medicare parts A, B, and C
  - Learn tips on billing crossovers successfully

ProviderOne System Updates

- Recent Discoveries Which Have Been Addressed
  - "Resubmit" feature in DDE
    - Medicare information was incorrectly posting in the commercial insurance fields
  - Rentals
    - Start date that crossed over from Medicare resulted in the application of a per diem rate to 30 day rental
  - Pricing
    - Some Medicare Only covered codes had to be manually priced
- Medicare Crossover Processing
- Electronic Claims processing much faster
  - Strongly encourage move from paper to electronic
  - Staff working to reduce inventory of paper claims

Common Terminology

- Coinsurance
  - An amount a Medicare client may be required to pay as their share of the cost for services after they pay any deductibles
    - Under Part A, coinsurance is a per day dollar amount.
    - Under Part B, coinsurance is generally 20% of allowed charges.
- Deductible
  - The amount for which a beneficiary is responsible before Medicare starts paying, or the initial, specific dollar amount for which the applicant or client is responsible.

Common Terminology (cont.)

- Explanation of Medicare Benefits (EOMB)
  - A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.
- Capitated Copayment
  - A predetermined set dollar amount received by a medical provider for services rendered paid by an insurance company regardless of utilization of those services
- Non-Capitated Copayment
  - A copayment received by a medical provider who also bills Fee For Service per visitation of the client

Overview - Medicare Crossovers

- Medicare Crossover Claims are claims for the client's Medicare cost sharing liability (deductible, coinsurance, or co-pay).
- There are 4 types of Medicare coverage:
  - Medicare Part A
    - Covers inpatient hospital services
  - Medicare Part B
    - Covers professional, outpatient hospital, and vendor services
  - Medicare Part C
    - A Managed Care version of Medicare, also called a Medicare Advantage Plan, offered through private insurance companies
  - Medicare Part D
    - Covers prescription drugs

Overview - Medicare Crossovers

- Must be contracted with both Medicare and Medicaid to bill HCA for secondary payment
- You must bill Medicare as the primary payer if Medicare covers the service provided.
- When is a claim a Medicare Crossover claim?
  - If you bill us secondary to Medicare and Medicare pays or applies to the deductible, it is a crossover
- When is a claim NOT a crossover claim?
  - Claims denied by Medicare are not crossover claims.
  - If you bill us secondary to Medicare, and Medicare does not pay.

    We still require the Medicare EOB to demonstrate non-payment.

Overview - Medicare Crossovers

- Sometimes Medicare does not forward claims automatically to the Agency
  - Can submit in Direct Data Entry without the EOMB.
- Medicare may not forward your crossover claim directly to the Agency because:
  - Patient is new Medicare/Medicaid enrollee and Medicare does not yet list them as having Medicaid.
  - You have billed Medicare with an NPI number that has not been reported to the Agency.
  - Electronic File Issues

Overview - Medicare Crossovers

- You will know if Medicare has not forwarded your crossover claim to the Agency if:
  - It does not show up on your Medical Assistance Remittance Advice; or
  - The message "This information is being sent to either a private insurer or Medicaid" or "MA07" does not show up on your EOMB.
- Things to consider
  - Why didn't your claim cross over from Medicare to begin with?
  - Why are you having to submit your crossovers to HCA?

Overview - Medicare Crossovers

- If Medicare denies a Medical Assistance-covered service that requires Prior Authorization, the service still requires authorization
  - You may request it after the service is provided.
  - The Agency waives the "prior" requirement in this circumstance.

Medicare Eligibility

- The client must have proper eligibility in order for secondary payment after Medicare can be considered.
  - QMB – Medicare Only (Qualified Medicare Beneficiary)
    - This program pays for Medicare premiums and pays for deductibles, coinsurance, and copayments according to Medicaid rules.
    - If Medicare covers the service, the Agency will consider secondary payment.
  - CNP-QMB (Categorically Needy Program – Qualified Medicare Beneficiary)
    - Client has full Medicaid as well as QMB benefits.

Medicare Eligibility

- Programs that HCA would not consider for secondary payment after Medicare
  - SLMB (Special Low Income Medicare Beneficiary)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - QI-1 (Qualified Individual 1)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - QDWI (Qualified Disabled Working Individual) –
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.

Medicare Eligibility

- Determine Medicare eligibility using ProviderOne

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	01/01/2004	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	01/01/2004	12/31/2999

  - The Medicare HIC number under the "Client Demographic Section"
  - MEV Vendors
  - Magnetic Swipe Card Readers
  - IVR system to obtain Medicare information
    - Page 45 - ProviderOne Billing & Resource Guide: http://hrsa.HCA.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html
  - Medicare Part C

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/201
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/201

The Medicare Crossover Process

Client is Eligible for Medicare and Medical Assistance

↓

Yes

↓

Bill Medicare

(*You must accept Medicare Assignment*)

↓

Medicare allows the service?

→ Yes

↓

Was the claim forwarded to HCA by Medicare?

→ YES -HCA processes the claim.

↓

No

↓

Submit your crossover claim to HCA within 6 months of the Medicare processing date. Make sure to use the same claim type you used to bill Medicare.

← No

↓

Your claim is not a crossover. Bill HCA within 365 days of Date of Service and submit the EOMB with your claim.

Washington State Health Care Authority

Crossover Payment Methodology

- **Professional Services (CMS-1500, 837P)**
  - **The Agency compares the Medical Assistance allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, then deducts Medicare's payment from the amount selected.**

    Payment = [lesser of Medicaid or Medicare Allowed] – Medicare Paid

Crossover Payment Methodology

- Professional Services (CMS-1500, 837P) cont.
  - If there is a balance due, the Agency pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.
  - If there is no balance due, the Agency does not make any crossover claim payment.

Crossover Payment Methodology

- Professional Services (CMS-1500, 837P) cont.
  - The Agency cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of Part B Medicare claim. The Agency can pay these costs to the provider on behalf of the client when:
    - The provider accepts assignment; and
    - The total combined payment to the provider from Medicare and Medical Assistance does not exceed Medicare or Medical Assistance's allowed amount for the service, whichever is less.

Crossover Payment Methodology

- Institutional Services (UB-04, 837I)
  - For institutional claims, Medical Assistance uses the total claim allowed amount to determine payment. Any payment made is applied toward the client's cost sharing liability (deductible, coinsurance, or co-pay).
  - In general the pricing methodology is:

  Payment = [Medicaid Allowed – Medicare Paid] or [Sum of Coinsurance + Deductible] (which ever is less)

  For full details, see the Inpatient Billing Instructions, page H.2 at http://hrsa.HCA.wa.gov/download/BI.html#H
- RHC and FQHC providers

Crossover Payment Methodology

- Institutional Services (UB-04, 837I) cont.
  - The Agency would adjust any payment amounts if the client has a Commercial Medicare supplement policy (TPL) and that supplement payer makes a payment after Medicare. In that case, the formula would be:
    - Payment = {[Medicaid Allowed – Medicare Paid] or [Sum of Coinsurance + Deductible] (which ever is less)} - TPL

MEDICARE BILLING PART B

Medicare Billing – Part B

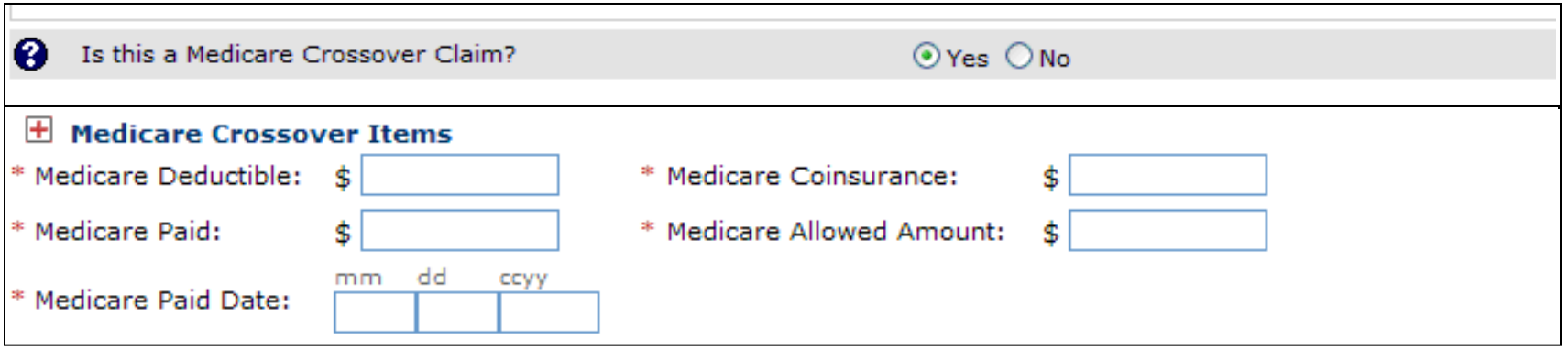
- CMS-1500, 837P
  - If Medicare has paid all lines on your claim ,submit the crossover claim to the Agency.
  - If Medicare has allowed and denied service lines on your claim, do not submit paid lines with denied lines to the Agency on the same claim, as this could cause a delay in payment.
    - You will need to submit 2 claims to the Agency;
      - one crossover claim for services Medicare paid and;
      - one professional claim for services Medicare denied.

Medicare Billing – Part B

- CMS-1500, 837P cont.
  - If Medicare denies a service that requires PRIOR authorization (PA) by the Agency, the Agency waives the PRIOR requirement
    - HCA still requires authorization for the service based on medical necessity ,which may be requested after the service is provided.
- Bill the Agency using the same claim format billed to Medicare with the same services and billed amounts. (Direct Data entry and EOMBs)
- Medicare is Medicare
  - HCA does not consider Medicare as insurance

Medicare Billing – Part B

- When submitting via Direct Data Entry (DDE)
  - Click the Radio button "yes" to indicate this claim is a crossover
  - Additional service item boxes open to be filled in as required.



- The rest of claim information is filled out as normal.
- If you bill a crossover using the DDE feature, the Agency does not require the EOMB.

Medicare Billing – Part B

- **HIPAA batch 837P**
  - **HIPAA companion guide http://hrsa.HCA.wa.gov/HCAHIPAA/attachments/pdf/837CG103009.pdf (beginning on page 41)**
  - **Medicare Information**
    - Loop 2320 – Other Subscriber Information
      - SBR04 – Medicare
      - SBR05 – MB
      - SBR09 – MB

Medicare Billing – Part B

- HIPAA Batch 837P continued
  - Medicare Payment Information
    - Loop 2320 – Coordination Of Benefits
      - AMT01 = D-Medicare Paid Amount
      - AMT01 = AAE-Medicare Approved Amount
      - AMT01 = B6-Medicare Allowed Amount
      - AMT01 = F5-Patient Paid Amount
    - Loop 2330B – Claim Adjudication Date
      - DTP03 = Medicare Paid Date (CCYYMMDD)

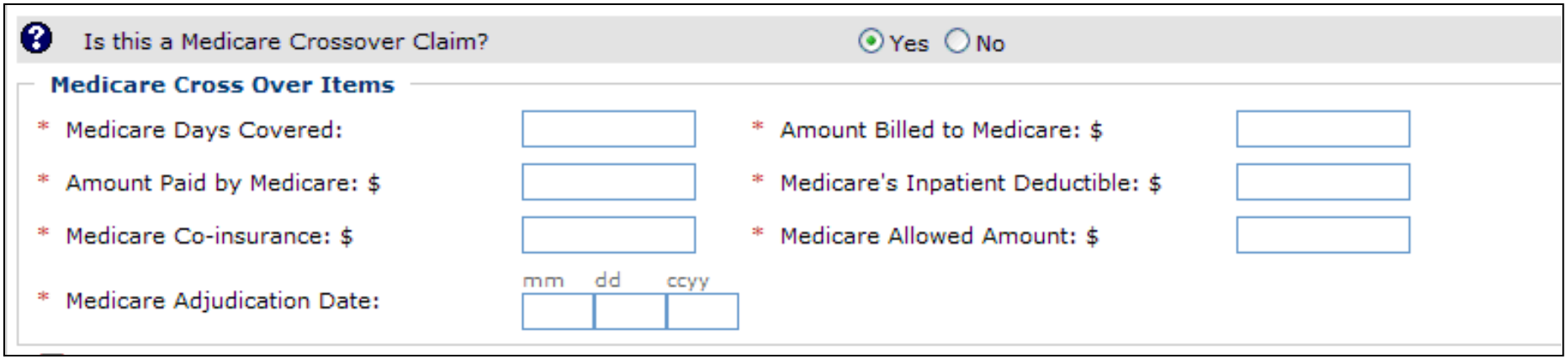
MEDICARE BILLING PART A

Medicare Billing – Part A

- UB-04, 837I
  - If you bill Medicare using the UB-04 claim format, you would bill the Agency using the same claim format. Include the same services and billed amounts you sent to Medicare.
- You can:
  - Submit DDE crossover claims in ProviderOne
  - or via electronic batch
- RHC note
  - One date of service per claim form

Medicare Billing – Part A

- When submitting DDE institutional crossover claims in ProviderOne, you will need to fill out additional information:
  - Click Radio button "yes" to indicate claim is a crossover
  - Additional service items boxes open to be filled in.



- The rest of claim is filled out as normal.

Medicare Billing – Part A

- HIPAA batch 837I
  - HIPAA companion guide http://hrsa.HCA.wa.gov/HCAHIPAA/attachments/pdf/837CG103009.pdf (beginning on page 81)
  - Medicare Information
    - Loop 2320 – Other Subscriber Information
      - SBR04 – Medicare
      - SBR09 – MA

Medicare Billing – Part A

- HIPAA Batch 837I continued
  - Medicare Payment Information
    - Loop 2320 – Claim Level Adjustment
      - CAS01 = PR-Patient Responsibility
      - CAS02 = 1-Deductible Amount
      - CAS02 = 2-CoInsurance
    - Loop 2320 – Coordination Of Benefits
      - AMT01 = B6-Medicare Allowed Amount
      - AMT01 = T3-Medicare Total Submitted Charges
      - AMT01 = N1-Medicare Paid Amount
    - Loop 2330B – Claim Adjudication Date
      - DTP03 = Medicare Paid Date (CCYYMMDD)

MEDICARE BILLING PART C

Medicare Billing – Part C

- Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C)
  - Providers are required to bill these Medicare Advantage Plans instead of FFS Medicare.
  - The Managed Medicare – Medicare Advantage Plan is the primary payer.
  - Follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing Medical Assistance
  - Medicare Advantage plans are still Medicare

Medicare Billing – Part C

- After Medicare Advantage plan processes the claim, submit the claim to Medical Assistance.
  - Bill Medical Assistance on the same claim format.
  - Make sure the services and billed amounts match what you billed to the Medicare Advantage plan.
  - No EOMB needed for DDE.
- The Agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

Medicare Billing – Part C

- If there is a Capitated Copayment due on claim:
  - Capitated copayments do not require the biller to submit a claim to the Agency with an explanation of benefits (EOB);
  - Indicate "Managed Medicare Capitated Copayment" on the billing forms as follows:
    - Electronic billing (DDE) in the "claim notes" section
    - CMS-1500 Claim Form in field 19;
    - UB-04 in form locator 80
  - Bill just the Capitated Copayment

Medicare Billing – Part C

- If there is coinsurance, a deductible, or a Noncapitated Copayment due on a claim:
  - If a balance is due for services provided
  - Indicate "Managed Medicare" on paper billing forms as follows:
    - CMS-1500 Claim Form in field 19;
    - UB-04 in form locator 80
  - No entry of "Managed Medicare" in Claim Notes needed for Direct Data Entry or electronic batch

Medicare Billing – Part C

- The Agency will compare the allowed amount for Medical Assistance and the Managed Medicare – Medicare Advantage Plan and select the lesser of the two.
  - Payment is based on the lesser of the allowed amounts minus any prior payment made by the Managed Medicare – Medicare Advantage Plan.
  - If Medicare Advantage denies a service on a claim, the Agency may or may not make a payment on the service depending on the reason for the Managed Medicare - Medicare Advantage Plan denial.
  - If no balance is due, the claim will be denied.

Medicare Billing – Part C

- If the Medicare Advantage Plan does not cover the service, the Agency does not pay for the service.
- Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to your Managed Medicare – Medicare Advantage plan.
  - If Managed Medicare - Medicare Advantage adjusts the payment and the claim has previously been paid, you may submit an adjustment request to Medical Assistance.
  - Submit a new claim if the original claim was denied.

Tips on Billing Crossovers

- Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.
- There may be a delay or denial in payment if any of the following situations occurs:
  - Billing Medicare with an NPI that has not been reported to Medical Assistance.
    - The Agency will not be able to identify the provider when these claims are forwarded by Medicare to Medical Assistance.
  - Billing a paper crossover claim to the Agency without a copy of the Medicare EOB attached.
    - This will cause your claim to be denied.
  - The claim format billed to Medicare does not match the claim format billed to Medical Assistance.
    - Your claim will be denied.

Tips on Billing Crossovers

- There may be a delay or denial in payment if any of the following situations occurs:
  - The coding and dollar amount billed do not match.
  - Discrepancies on Medicare Coverage
- Final consideration for billing and taxonomy codes when submitting claims to Medicare

Tips on Billing Crossovers

- Go Electronic!
- It's faster!
- It's easy!
- No EOMB required!
- Reduce denials for duplications!